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How Can Care Management Improve Patient Outcomes? Focus on Risk Stratification

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How Can Care Management Improve Patient Outcomes?
Focus on Risk Stratification

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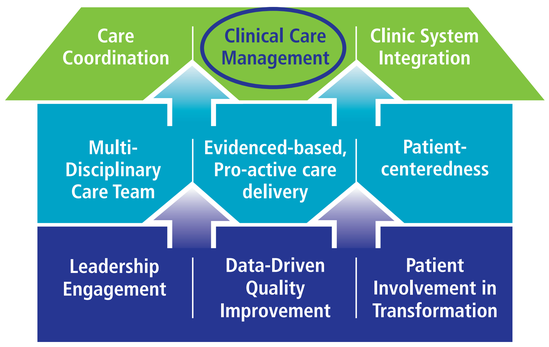
PROBLEM STATEMENT/BACKGROUND

Providing Clinical Care Management to the highest risk, most complex and costly patients is very important for primary care practices recognized as a Patient Centered Medical Home (PCMH). This is a new service for most primary care practices.

Identifying patients who would most likely benefit from Clinical Care Management services is an important first step. This will help direct the appropriate resources and interventions to mitigate risk and improve outcomes for individual patients and help practices achieve their PCMH goals.

AIMS

- Identify the key elements for practice-based Risk Stratification methods
- Identify approaches for measuring and evaluating effectiveness of Risk Stratification and Clinical Care Management at the practice level



Why Clinical Care Management?

- Half of US health care dollars are spent on 5% of the population[1]
- Annual medical expenses for patients with both chronic medical and behavioral health conditions are 46% more than that of patients who have chronic medical conditions only[2]
- The top 10% of health care users consume 33% of ambulatory and approximately 50% of inpatient services[2]
- Overall, care integration helps to:[3]
  - Enhance holistic, patient-centered care
  - Improve overall health outcomes
  - Increase efficiency and access to care
  - Minimize stigma and discrimination
  - Reduce costs

Does Clinical Care Management Work? **YES!**

- PCMH practices had significantly reduced costs and utilization for the highest risk patients, particularly with respect to inpatient care[4]
- Reduced costs[5]
- Reduced hospital admissions and stays[6]
- Higher patient satisfaction[7]
- Reduction of depression symptoms[8]
- Improvements in blood glucose control[9]
- Improved health behaviors (e.g., exercise)[10]

Massachusetts Primary Care Reform Initiatives

Massachusetts Patient Centered Medical Home Initiative (MA PCMHI)

- Multi-payer, statewide initiative
- Sponsored by Massachusetts Health & Human Services; legislatively mandated
- 46 participating practices
- 3-year demonstration: March, 2011 - March, 2014
- Included payment reform and technical assistance

Primary Care Payment Reform (PCPR)

- Single-payer
- Massachusetts Medicaid's flagship alternative payment program that will enable the move from fee-for-service reimbursement towards alternative payment models.
- Improve access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health.
- 30 participating practice organizations, approximately 50 sites
- 3-year project: March, 2014 - March, 2017

Clinical Care Management Population of Focus

Adapted from: ©IMacColl Institute for Healthcare Innovation, Group Health Research Institute 2011.

Care Coordination & Clinical Care Management
Overlap & Differences...

Care Coordination

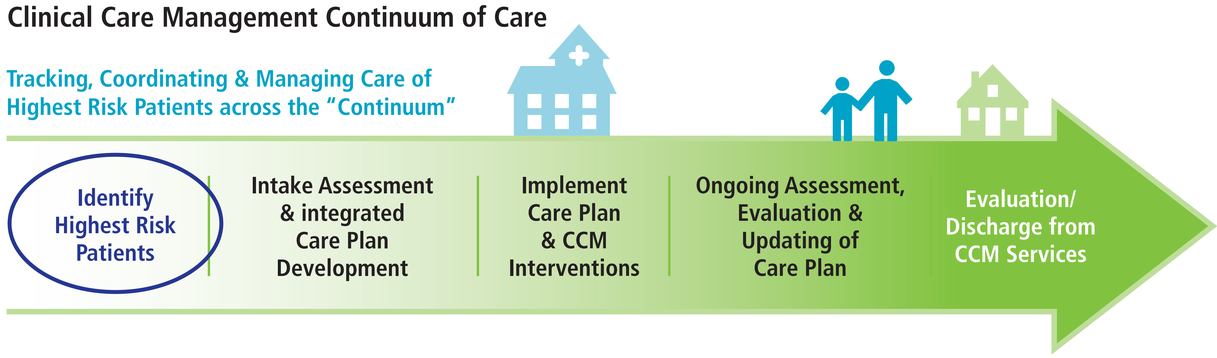
- Track & assist patients across care settings
- Coordinate care & services
- Timely follow-up of ED visits & hospital discharges
- Exchange of information across care settings
- Smooth transitions of care
- Referral & information sharing protocols – Primary Care & Behavioral Health Providers
- Community service referrals

Clinical Care Management = Care Coordination **+**

- Care Plan development
- Frequent contact with patient
- Clinical assessment & monitoring
- Medication with reconciliation
- Intense medication management
- Self management support
- Patient teaching
- Development & implementation of the Integrated Care Plan
- Bi-directional communication with treating professionals

Clinical Care Management Continuum of Care

Tracking, Coordinating & Managing Care of Highest Risk Patients across the "Continuum"



PRACTICE-BASED RISK STRATIFICATION APPROACHES

Primary Care Risk Stratification

- Helps a practice efficiently, systematically, and statistically better understand patients and their risk for future costs
- Provides information about which members may need clinical care management the most
- Employs utilization information such as hospitalization and ED use

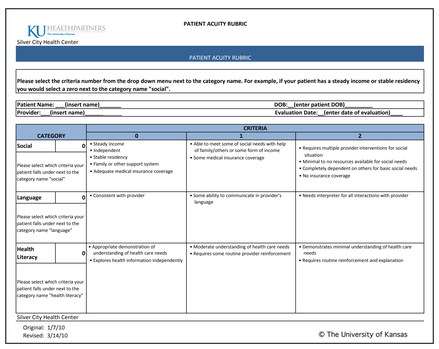
Simplest Approach

- Ask providers which patients they are most concerned about – which patients they consider most at risk for:
  - Hospitalization/ED utilization
  - Sentinel events
  - Adverse outcomes
- Each provider identifies top 3-5% of their panel, or specified number of patients based on Clinical Care Management capacity

Some Criteria to Consider:

- Stratify patients based on:
  - Disease severity
  - Co-morbidities
  - Self-care deficits
  - Poly-pharmacy
  - Behavioral health issues
  - Socioeconomic factors
  - Healthcare utilization trends
  - Availability of family/social support mechanisms

Example of a Practice-Based Risk Stratification Tool: Patient Acuity Rubric



PATIENT ACUITY RUBRIC

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PATIENT ACUITY RUBRIC

Please select the criteria number from the drop down menu next to the category name. For example, if your patient has a steady income or stable residency you would select a zero next to the category name "social".

Patient Name: ___(insert name)___ DOB: ___(enter patient DOB)___
Provider: ___(insert name)___ Evaluation Date: ___(enter date of evaluation)___

CATEGORY		CRITERIA 0	1	2
Social	0	• Steady income • Independent • Stable residency • Family or other support system • Adequate medical insurance coverage	• Able to meet some of social needs with help of family/others or some form of income • Some medical insurance coverage	• Requires multiple provider interventions for social situation • Minimal to no resources available for social needs • Completely dependent on others for basic social needs • No insurance coverage
Please select which criteria your patient falls under next to the category name "social"				
Language	0	• Consistent with provider	• Some ability to communicate in provider's language	• Needs interpreter for all interactions with provider
Please select which criteria your patient falls under next to the category name "language"				
Health Literacy	0	• Appropriate demonstration of understanding of health care needs • Explores health information independently	• Moderate understanding of health care needs • Requires some routine provider reinforcement	• Demonstrates minimal understanding of health care needs • Requires routine reinforcement and explanation
Please select which criteria your patient falls under next to the category name "health literacy"				

Silver City Health Center
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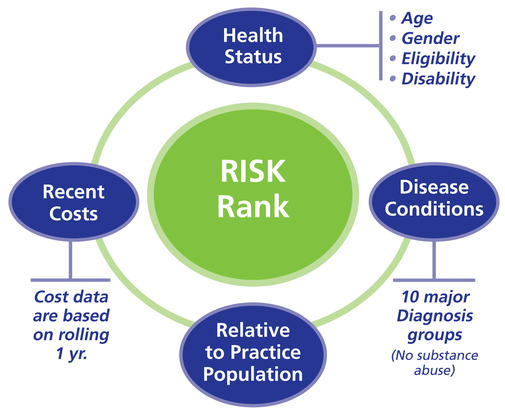
Source: safetynetmedicalhome.org

Example of a Payer-Based Risk Stratification Tool: DxCG High Risk Ranking



Advantages/Limitations of Payer Member Reports

Advantages	• Last primary care practice visit within six months • ED and hospital utilization with diagnoses • Most recent contact information
Limitations	• Patients listed may not be priority of provider and team • Month lag with utilization data • No substance abuse utilization and diagnoses

Carlevale, J. and Johnson, C. – Risk Stratification – Practical Applications in the PCPR. (Webinar) – August, 2014.

Workflow Example – Combining Payer & Practice-based risk stratification data

Generate high risk practice list (level of complexity will vary depending on practice capacity).

Compare practice high risk list with payer high risk list. Generate merged list to reflect only patients common to both lists.

If no matches, use practice based list to identify patients who have not received treatment in the last six months. Outreach to these patients and during visit, perform assessment and/or use payer high risk list.

When matches exist, integrate Payer data with EMR data (A1c, BP, ED utilization, diagnoses etc.) **for care team review and determination of care plan.**

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Risk Stratification in the MA PCMHI

- PCMHI practices prospectively generated a list of patients who might benefit from additional care using clinical measures and utilization information such as hospitalization and ED use
- Some practices developed risk stratification tools that integrated other practice-specific conditions of interest:
  - Co-morbidities
  - Self-care deficits
  - Poly-pharmacy
  - Availability of family/social support mechanisms
  - Behavioral health issues

Risk Stratification in the PCPR

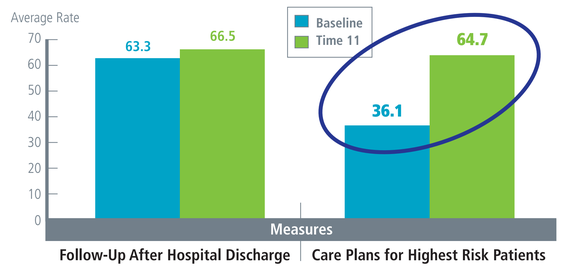
- PCPR participating practices are provided a **payer-generated list** of patients for whom additional care – either Care Coordination and/or Clinical Care Management services – is expected
- Practices also receive a **list of patients who are considered high risk** based on payer algorithm
- Practices conduct retrospective risk assessment on this list
  - Compare practice-based list with the two lists provided and generate a list of common patients
    - Integrate data sources for care team review and determination of care plan
  - If no common patients:
    - Use practice based list to identify patients who have not received treatment in the last six months & initiate outreach
    - Use payer high risk list exclusively to guide service delivery

Clinical Care Management Performance Metrics

- Change in patient acuity rubric score
  - Individual
  - For cohort over time
- Number of high risk patients in active Clinical Care Management
- Reduction in avoidable ED visits
- Reduction in avoidable inpatient admissions
- Number of patients in care management who are achieving individual patient-centered goals

Results: Care Coordination/Care Management Measures

Change over Time in MA PCMHI



Values met the study's definition of statistical significance p<.05.

SUMMARY

Risk Stratification is the foundational step in establishing delivery of practice-based clinical care management services.

- Allows practices to identify patients who would benefit most from clinical care management services
- Allows creation of a High Risk Registry based on practice and payer data and identification of patients who need integrated care plans
- Helps identify resources needed to support patients and families and to plan new workflows related to this process
- Helps practices assess effectiveness by developing applicable process and outcome measures that support patient and practice Clinical Care Management goals

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